House of Representatives

General Assembly

File No. 520

January Session, 2011

Substitute House Bill No. 6392

House of Representatives, April 13, 2011

The Committee on Public Health reported through REP. RITTER, E. of the 38th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING BIRTH-TO-THREE SERVICES AND REHABILITATION SERVICES FOR CHRONIC GAMBLERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide **[**(1)**]** coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2)**]** No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible

limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 2. Section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide **[**(1)**]** coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2)**]** No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, except that for a child with autism spectrum disorders, as defined in section 38a-514b, who is receiving early intervention services as defined in section 17a-248, the maximum benefit available through early intervention providers shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period as provided for in section 38a-514b. Nothing in this section shall be construed to increase the amount of coverage required for autism spectrum disorders for any child beyond the amounts set forth in section 38a-514b. Any coverage provided for autism spectrum disorders through an

individualized family service plan pursuant to section 17a-248e shall be credited toward the coverage amounts required under section 38a-514b. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 3. Section 12-818 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

For each of the fiscal years ending June 30, 2010, and June 30, 2011, the Connecticut Lottery Corporation shall transfer one million nine hundred thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment rehabilitation account created pursuant to section 17a-713. For the fiscal year ending June 30, 2012, and each fiscal year thereafter, the Connecticut Lottery Corporation shall transfer one million **[**five**]** nine hundred thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment rehabilitation account created pursuant to section 17a-713.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2011*	38a-490a
Sec. 2	*July 1, 2011*	38a-516a
Sec. 3	*July 1, 2011*	12-818

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Department of Developmental Services	GF - Savings	($1,600,000)	($3,200,000)
State Comptroller - Fringe Benefits	GF & TF - Cost	Potential	Potential
Mental Health & Addiction Serv., Dept.	Chronic Gamblers Account - Revenue Gain	$400,000	$400,000
Resources of the General Fund	GF - Revenue Loss	($400,000)	($400,000)

Note: GF=General Fund nd and TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 12 $	FY 13 $
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

Section 1 and 2 of the bill result in a savings of $1.6 million in FY 12 and $3.2 million in FY 13 in the Department of Developmental Services' (DDS) Early Intervention account, which funds the Birth-to-Three Program. These savings would be offset by potential costs incurred by the state employee health plan.

The savings to DDS are the result of making the following two insurance changes:

1. Eliminate co-payments and deductibles for Birth-to-Three services, and

2. Raise the annual cap on insurance payments from $6,400 per

year to $50,000 per year for children with autism spectrum disorder receiving Birth-to-Three services.

The additional insurance revenue generated from these changes will reduce the level of appropriation required to fund the Birth-to-Three Program.

Impact to the State Employee Health Plan and Municipalities

As of July 1, 2010, the State Employees' Health Plan went self insured. Pursuant to current federal law, the state's self-insured plan would be exempt from state health insurance benefit mandates. However, in previous self-funded arrangements the state has traditionally adopted all state mandates. To the extent that the state continues this practice of voluntary mandate adoption the following impact would be anticipated.

Section 1 and 2 of the bill will result in an increased cost to the state employee health plan because of the two changes to insurance referenced above. Current law requires an annual maximum policy benefit of $6,400 per child. The bill expands the annual maximum policy benefit for children with autism spectrum disorder to $50,000. This is a $43,600 increase in the annual maximum policy benefit (a $130,800 increase in the aggregate maximum policy benefit for the three years of services). The potential cost would depend on the utilization of services, the level of which is indeterminate at this time.

Section 1 and 2 of the bill may increase costs to fully insured municipal plans which currently require copays or other cost-sharing for Birth-to-Three services. In addition, there may be an increased cost to fully insured municipalities who do not provide the level of coverage specified in the bill for services for children with autism. The coverage requirements may result in increased premium costs when municipalities enter into new health coverage contracts after July 1, 2011. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The state and many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordability Care Act (PPACA)[1]. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of the state plan and certain municipal plans PPACA[2].

Section 3 of the bill increases, from $1.5 million to $1.9 million, the amount of lottery revenue that must be dedicated annually to the Chronic Gamblers Treatment Rehabilitation Account within the Department of Mental Health and Addiction Services. This results in a $400,000 revenue loss to the General Fund and a commensurate revenue gain to the Chronic Gamblers Treatment Rehabilitation Account.

The Out Years

The annualized ongoing fiscal impact identified above for sections 1 and 2 would continue into the future subject to inflation. The annualized ongoing revenue impact identified above for section 3 would remain constant into the future as transfer amounts are set by statute.

The federal health care reform act requires that, effective January 1, 2014, all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in

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[1] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

[2] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

OLR Bill Analysis

sHB 6392

AN ACT CONCERNING BIRTH-TO-THREE SERVICES AND REHABILITATION SERVICES FOR CHRONIC GAMBLERS.

SUMMARY:

Beginning in FY 12, this bill increases from $1.5 million to $1.9 million, the amount of lottery revenue that the Connecticut Lottery Corporation must annually transfer to the chronic gamblers treatment rehabilitation account (PA 09-3, JSS, transferred $1.9 million in FY 10 and FY 11).

The bill also makes changes to the coverage requirements for health insurance policies that provide coverage for medically necessary early intervention (birth-to-three) provided as part of an individualized family service plan and it prohibits these policies from imposing co-insurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless they are high-deductible policies designed to be compatible with federally qualified health savings accounts.

It applies to individual and group health insurance policies delivered, issued, or renewed in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act (ERISA), state health insurance mandates do not apply to self-insured plans.

The bill also increases the annual maximum benefit group health insurers must provide for children with autism spectrum disorders who receive birth-to-three services.

EFFECTIVE DATE: July 1, 2011

BIRTH-TO-THREE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS

By law, group health insurance policies must cover medically necessary birth-to-three services provided as part of an individualized family service plan. This coverage must include an annual maximum policy benefit of $6,400 per child, with an aggregate benefit of $19,200 per child over the three-year period. The bill expands these coverage amounts for children with autism spectrum disorders to $50,000 per child per year and $150,000 per child over the three-year period.

Current law also requires group health insurance policies to cover the diagnosis and treatment of autism spectrum disorders. Policies can limit the coverage for behavioral therapy to an annual benefit of $50,000 for a child under age nine. But, they must provide unlimited visits to autism services providers if the services are medically necessary (for services such as occupational, physical, and speech therapies). The bill specifies that coverage provided through a birth-to-three individualized service plan must (1) be credited toward these coverage amounts and (2) does not increase these coverage amounts.

The bill applies to group health insurance policies delivered, issued, or renewed in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act (ERISA), state health insurance mandates do not apply to self-insured plans.

BACKGROUND

Chronic Gamblers Treatment Rehabilitation Account

This account partially funds the Department of Mental Health and Addiction Services' compulsive gambling treatment program. The balance of the funding comes from a fee imposed on dog racing, jai alai, and teletheater licenses. The program provides prevention, treatment, and rehabilitation services for chronic gamblers.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 26 Nay 2 (03/28/2011)